| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>A recertification survey and complaint investigation #39814, #40606, #40012, and #40013 were completed on 5/3/17 at Manchester Health Care Center. No deficiencies were cited related to complaint investigation #39814. Deficiencies were cited related to the recertification survey and complaint investigation #40606, #40012, and #40013 under 42 CFR PART 483, Requirements for Long Term Care Facilities. | F 000 | | |
| F 225 SS=E | 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>483.12(a) The facility must-<br><br>(3) Not employ or otherwise engage individuals who-<br><br>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;<br><br>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or<br><br>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.<br><br>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a | F 225 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 225 | Continued From page 1<br>nurse aide or other facility staff.<br><br>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy review, medical record | F 225 | | |

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| F 225 | Continued From page 2<br>review, facility investigation review, and interview, the facility failed to conduct an investigation of an injury of unknown origin for 1 resident (#175) of 3 residents reviewed for injuries of unknown origin and failed to throughly investigate two behavior related incidents involving three residents (#176, #45, #112) of 19 residents reviewed for behaviors.<br><br>The findings included:<br><br>Review of facility policy, Abuse Prevention Standard, revised 9/2015 revealed "...the facility shall not condone any acts of resident mistreatment, neglect, verbal, sexual, physical, and/or mental abuse, corporal punishment, involuntary seclusion, or misappropriation of resident property by any facility staff member, other residents, consultants, volunteers, staff of other agencies, family members, legal guardians, friends, or other individuals...The facility will thoroughly investigate, under the direction of the Administrator, all injuries of unknown origin to determine if abuse or neglect was involved...The results of the investigating will be reviewed by the facility's Quality Assurance/Performance Improvement Committee [QAPI] and entered into the minutes..."<br><br>Medical record review revealed Resident #175 was admitted to the facility on 8/31/16 with diagnoses including Congestive Heart Failure, Hypertension, Gastroesophageal Reflux Disease, Osteoarthritis, and Right Tibial Plateau Fracture.<br><br>Medical record review of the Quarterly Minimum Data Set (MDS) dated 9/7/16 revealed Resident #175 scored 15 on the Brief Interview for Mental Status indicating she was alert, oriented, and able | F 225 | | |

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| F 225 | Continued From page 3<br>to make her needs known. Continued review revealed Resident #175 required extensive assist of 1 person for transfers, dressing, grooming, and bathing; setup for eating; was always continent of bladder and occasionally incontinent of bowel.<br><br>Review of facility policy, Abuse and Event Management Standard, revised 9/2015 revealed, "...Resident-to-Resident Abuse Policy...All incidents are to be documented in the resident's medical record with intense monitoring to continue for at least 72 hours...Reporting/Investingation/Response Policy...Facility Social Worker Duties...to provide counseling and support to the resident...to be documented in the resident's clinical record..."<br><br>Review of the Fast Pace-v3-14 form dated 10/28/16 at 2:30 PM revealed a Resident-to-Resident altercation dated 10/27/16 at 5:00 PM in the fine dining room, between Resident #45 and Resident #176. The altercation consisted of Resident #176 initiating a verbal exchange with Resident #45, concluding in Resident #176 hitting Resident #45 on the legs above the knees.<br><br>Medical record review revealed Resident #45 was admitted to the facility on 7/28/16 with diagnoses including Iron Deficiency Anemia, Chronic Kidney Disease-Stage 4, Major Depressive Disorder, Anxiety Disorder, Multiple Sclerosis with Quadriplegia, Hypertension, Diabetes Mellitus with Diabetic Neuropathy, Atrial Fibrillation, Neuromuscular Dysfunction of Bladder with Urinary Incontinence, and Generalized Muscle Weakness.<br><br>Medical record review revealed Resident #176 | F 225 | | |

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| F 225 | Continued From page 4<br>was admitted to the facility on 8/24/16 with diagnoses including Traumatic Brain Injury, Anxiety Disorder, Major Depressive Disorder, Blindness-both eyes, Generalized Muscle Weakness, and Cognitive Communication Deficit.<br><br>Medical record review of the Progress Notes, dated 10/27/16 revealed, "...resident [#45] involved in an incident with another resident [#176]...resulted...getting struck by other resident [#176]...will continue to monitor..." Continued review revealed no further documentation or monitoring noted. Resident #45 was asked to allow nursing to assess him and he refused. Resident #176 was transferred to a facility providing behavior monitoring and management on 10/27/16.<br><br>Medical record review revealed no documentation of follow-up by Social Services for Resident #45 following the Resident-to-Resident altercation dated 10/27/16.<br><br>Interview with the Administrator on 5/3/17 at 11:30 AM in the Adminstrator's office confirmed the investigation provided was the only information available for 10/27/16 Resident-to Resident altercation.<br><br>Interview with the DON on 5/3/17 at 2:00 PM in the Conference Room confirmed there was no documentation for, "...intense monitoring to continue for at least 72 hours..." per facility policy. Further interview confirmed Social Services failed to follow-up or investigate the Resident-to-Resident altercation 10/27/16 involving Resident #45 and Resident #176.<br><br>Review of an Orthopedics follow-up appointment | F 225 | | |

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| F 225 | Continued From page 5<br>dated 9/7/16 revealed Resident #175 was complaining of right knee and hip pain. The physician felt the hip pain was knee pain referred to the hip. An x-ray of the knee was ordered but no x-ray of the hip was ordered.<br><br>Medical record review of a Nurse Practitioner note dated 10/6/16 revealed Resident #175 complained of pain in her right lower extremity but less than previously so the scheduled Percocet (pain medication) was changed to as needed. It was also documented Resident #175 had a medical history of osteoporosis.<br><br>Medical record review of a Nurse Practitioner note dated 10/10/16, revealed Resident #175 complained of severe right hip pain. The pain was described as a constant ache increasing to sharp with movement. The pain was unrelieved by the current care plan and the resident needed a hip x-ray which was done on 10/10/16 and was read as "...no fracture or dislocation but if symptoms persist, repeat imaging in a few days or additional imaging with CT [computerized tomography] or MRI [magnetic resonance imaging] may be necessary for further evaluation..."<br><br>Medical record review of a Nurse Practitioner note dated 10/12/16 revealed Resident #175 complained of muscle pain/spasm in the right hip and groin area. The pain was described as an intermittent ache and throb.<br><br>Medical record review of a Nurse Practitioner note dated 10/18/16 revealed Resident #175 was to be non weight bearing on the right lower extremity until cleared by Orthopedics. The tibial plateau fracture was stable but not healed. The resident was able to do passive range of motion | F 225 | | |

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| F 225 | Continued From page 6<br>exercises with the right knee. The x-ray from 10/10/16 was suspicious for a femoral neck fracture or other type of hip fracture so an MRI was ordered.<br><br>Medical record review of nursing notes dated 11/2/16 revealed Resident #175 had an MRI of the right hip.<br><br>Medical record review of a nursing note dated 11/4/16 revealed the nurse spoke to Resident #175 about impending transport and admission to the hospital due to recent hip fracture. The resident stated she had no falls since admission but her thigh and right hip just started hurting.<br><br>Medical record review of nursing notes dated 11/8/16 revealed Resident #175 was to have surgery on the right hip that same evening and be transferred to a nursing facility closer to her family after recovery.<br><br>Medical record review of a radiology report of the right hip dated 11/12/16 revealed Resident #175 had "...diffuse edema in soft tissues and the proximal femur as well as a subcapital fracture [below the neck of the femur] mildly impacted of the femoral neck. Edema extends into the gluteus maximus and medium muscles [buttocks muscles] and into the thigh muscles..."<br><br>Medical record review of a physician's note dated 11/29/16 revealed "...It is my professional opinion after reviewing documentation and diagnostics the resident's right femoral neck fracture identified on 11/2/16 is pathological in nature. The resident's age and medical history of osteoporosis are contributing factors to this conclusion..." | F 225 | | |

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| F 225 | Continued From page 7<br><br>Review of the facility's investigation packet revealed no evidence of an investigation. There were no statements from staff regarding any falls sustained by Resident #175 as well as assistance required by the resident. There was no documentation from staff, therapy, or roommate regarding possible causes of the injury of unknown origin.<br><br>Interview with Certified Nursing Aide #6 (CNA) on 5/3/17 at 1:30 PM on the 300 hall where Resident #175 had resided, revealed she was unaware of any falls the resident sustained while in the facility. CNA #6 also stated Resident #175 required a lot of assistance with all Activities of Daily Living (ADL) because of the tibial fracture of her right leg.<br><br>Interview with CNA #7 on 5/3/17 at 1:45 PM on the 300 hall, revealed she was unaware of any falls the resident had while in the facility. She did not witness any falls nor did the resident complain of falling to CNA #7. The CNA also stated Resident #175 required assistance with transfers as well as ADLs so the staff would have been aware if the resident had fallen.<br><br>Interview with the Director of Rehab, on 5/3/17 at 3:00 PM in the conference room, revealed Resident #175 was alert and oriented and had sustained a tibia/fibula fracture during a fall at home. The Director stated the resident was non weight-bearing on the right leg. Continued interview with the Director revealed Resident #175 had no falls while in the facility. Resident #175 complained of increasing hip pain so was sent to the hospital where a hip fracture was found. The resident had gone to an Orthopedic | F 225 | | |

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| F 225 | Continued From page 8<br>appointment earlier but no fracture was found.<br><br>Interview with the Director of Nursing (DON) on 5/3/17 at 4:20 PM in the conference room, revealed she was unable to recall the resident or any issues with her. Continued interview the DON confirmed there was no completed investigation into the injury of unknown origin.<br><br>Review of facility policy, Abuse and Event Management Standard, revised 9/15 revealed "...It is the policy of this facility to take all steps reasonable and necessary to protect the residents from harm at all times, including protection from physical and verbal abuse from other residents...The Administrator, Director of Nursing or their designee assumes responsibility for notification of the incident and investigation findings as well as follow-up...An investigation report is to be completed, to include the written summary of the investigation and facility actions taken..."<br><br>Medical record review revealed Resident #112 was admitted to the facility on 12/13/14 and readmitted on 12/17/16 with diagnoses including Huntington's Disease, Restlessness and Agitation, Other Specified Mental Disorders due to known Physiological Condition, Depression, Muscle Weakness, Ataxic Gait, Anxiety, and History of Falling.<br><br>Medical record review of the 5-day MDS assessment dated 12/13/16 revealed Resident #112 had a BIMS of 14 indicating the resident was cognitively intact.<br><br>Medical record review of a nurse's note dated 12/18/16 revealed "...Resident got a hold of fire | F 225 | | |

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| F 225 | Continued From page 9<br>extinguisher and pulled pin and ran down 200 hallway spraying every where...Told resident to stop but he would not...Police approached him and attempted to just talk to him but he made a fist and attempted to hit one of the officers..."<br><br>Medical record review of a Social Service note dated 12/20/16 revealed "resident was discharged on 12/18 with behaviors."<br><br>Review of the facility investigation received from the DON on 5/2/17 in the conference room revealed one undated typed note from the Social Director which documented "Spoke with residents that were interviewable about the incident that occurred on 12/18. No resident seemed to have any psychosocial factors other than wanting to know when they were going to get some of their personal belonging back from housekeeping. This social worker informed the residents that they were being washed and would be returned after being cleaned." Continued review of the facility investigation revealed 6 employee statements recounting their rememberances of the fire extinguisher incident. Further review revealed one witness statement report from a resident in Room 204B that was hit by and sprayed with the fire extinguisher who received an evaluation at the Emergency Department with no injuries. Continued review revealed an In-Service form dated 12/18/16 "...Topic...Be aware of resident behavior that would indicate an interest in fire extinguisher or pull stations..." signed by 20 employees.<br><br>Interview with the DON on 5/3/17 at 2:50 PM in the conference room revealed there was no other available information for the facility investigation. Continued interview confirmed the facility failed to | F 225 | | |

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| F 225 | Continued From page 10<br>conduct and document a complete and thorough investigation for Resident #112's behaviors and fire extinguisher incident that occurred in December 2016.<br><br>Review of facility policy, Abuse and Event Management Standard, revised 9/2015 revealed, "...Resident-to-Resident Abuse Policy...All incidents are to be documented in the resident's medical record with intense monitoring to continue for at least 72 hours...Reporting/Investingation/Response Policy...Facility Social Worker Duties...to provide counseling and support to the resident...to be documented in the resident's clinical record..."<br><br>Review of the Fast Pace-v3-14 form dated 10/28/16 at 2:30 PM revealed a Resident-to-Resident altercation dated 10/27/16 at 5:00 PM in the fine dining room, between Resident #45 and Resident #176. The altercation consisted of Resident #176 initiating a verbal exchange with Resident #45, concluding in Resident #176 hitting Resident #45 on the legs above the knees.<br><br>Medical record review revealed Resident #45 was admitted to the facility on 7/28/16 with diagnoses including Iron Deficiency Anemia, Chronic Kidney Disease-Stage 4, Major Depressive Disorder, Anxiety Disorder, Multiple Sclerosis with Quadriplegia, Hypertension, Diabetes Mellitus with Diabetic Neuropathy, Atrial Fibrillation, Neuromuscular Dysfunction of Bladder with Urinary Incontinence, and Generalized Muscle Weakness.<br><br>Medical record review revealed Resident #176 was admitted to the facility on 8/24/16 with | F 225 | | |

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| F 225 | Continued From page 11<br>diagnoses including Traumatic Brain Injury, Anxiety Disorder, Major Depressive Disorder, Blindness-both eyes, Generalized Muscle Weakness, and Cognitive Communication Deficit.<br><br>Medical record review of the Progress Notes, dated 10/27/16 revealed, "...resident [#45] involved in an incident with another resident [#176]...resulted...getting struck by other resident [#176]...will continue to monitor..." Continued review revealed no further documentation or monitoring noted. Resident #45 was asked to allow nursing to assess him and he refused. Resident #176 was transferred to a facility providing behavior monitoring and management on 10/27/16.<br><br>Medical record review revealed no documentation of follow-up by Social Services for Resident #45 following the Resident-to-Resident altercation dated 10/27/16.<br><br>Interview with the Administrator on 5/3/17 at 11:30 AM in the Adminstrator's office confirmed the investigation provided was the only information available for 10/27/16 Resident-to Resident altercation.<br><br>Interview with the DON on 5/3/17 at 2:00 PM in the Conference Room confirmed there was no documentation for, "...intense monitoring to continue for at least 72 hours..." per facility policy. Further interview confirmed Social Services failed to follow-up or investigate the Resident-to-Resident altercation 10/27/16 involving Resident #45 and Resident #176. | F 225 | | |
| F 253 SS=E | 483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES | F 253 | | |

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| F 253 | Continued From page 12<br><br>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to maintain sanitary resident bathrooms for 2 of 5 halls.<br><br>The findings included:<br><br>Observation on 5/1/17 of the resident's bathroom shower floor and the floor area around the commode revealed the following:<br><br>Room 302 at 1:05 PM and 3:07 PM-bathroom shower floor grout and the floor area around the commode were blackened with debris.<br><br>Room 306 at 2:28 PM-bathroom shower floor grout blackened with debris and the floor area around the commode had brown debris present.<br><br>Room 307 at 2:51 PM-bathroom shower floor grout was blackened with debris and the floor area around the commode was brown with debris.<br><br>Room 309 at 8:35 AM-floor area around the commode was black/brown with debris.<br><br>Room 311 at 8:36 AM- floor area around the commode were black/brown with debris.<br><br>Room 504 at 7:36 AM-bathroom shower floor grout was blackened with debris.<br><br>Room 505 at 3:09 PM-bathroom shower floor had | F 253 | | |

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| F 253 | Continued From page 13<br>debris present.<br><br>Room 506 at 11:13 AM and 3:25 PM-bathroom shower floor had 2 smeared brown colored areas of debris present, the shower floor grout and the floor surrounding the commode were blackened with debris.<br><br>Observation on 5/2/17 beginning at 10:48 AM and a second observation beginning at 4:00 PM, with the Housekeeping Supervisor present, of the resident's bathroom shower floor and the floor area around the commode revealed the following:<br><br>Rooms 302, 306, 307, 309, 311, 504, and 507-bathroom shower floor and floor surrounding the commode had debris present.<br><br>Room 506-bathroom shower floor grout and the floor surrounding the commode had blackened debris present. Further observation revealed 2 smeared brown colored areas of debris on the shower floor initially observed on 5/1/17 at 11:13 AM and 3:25 PM.<br><br>Interview with the Housekeeping Supervisor on 5/2/17 at 4:11 PM in the 500 hall confirmed the facility failed to maintain the resident's shower floor and the floor surrounding the commode on the 300 and 500 halls in a sanitary manner. Further interview confirmed Room 506's shower floor had 2 smeared brown colored areas of debris present. | F 253 | | |
| F 278 SS=D | 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. | F 278 | | |

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| F 278 | Continued From page 14<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and interview, the facility failed to accurately assess the antidepressant medication administration for 1 (#60) of 33 residents reviewed on the stage 2 sample. | F 278 | | |

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| F 278 | Continued From page 15<br>The findings included:<br><br>Medical record review revealed Resident #60 was admitted to the facility on 7/18/14 with diagnoses including Dementia without Behaviors, Chronic Lymphocytic Leukemia, Diabetes Mellitus Type II, Essential Hypertension, Peripheral Vascular Disease, Atrial Fibrillation, Cardiac Arrhythmias, Hypothyroidism, Anxiety Disorder, Hyperlipidemia, and Major Depressive Disorder.<br><br>Medical record review revealed physician's telephone order dated 3/17/17 for Zoloft (Antidepressant) 25 mg (milligram) PO (by mouth) with evening meal.<br><br>Medical record review of Medication Administration Record for 3/2017 revealed administration of Zoloft 25 mg orally daily each evening.<br><br>Medical record review of the Quarterly Minimum Data Set (MDS) dated 3/24/17 for Resident #60 revealed no antidepressant medication administration during 7 day review period.<br><br>Interview with MDS Coordinator and her assistant, on 5/3/17 at 3:23 PM in the MDS office revealed, when asked if the Quarterly MDS dated 3/24/17 accurately assessed the Antidepressant Administration for Resident #60, the MDS Coordinator and her assistant both stated, "...must have missed that one..." Further interview, the MDS Coordinator confirmed the facility failed to accurately assess the antidepressant medication administration on the Quarterly MDS. | F 278 | | |
| F 279 | 483.20(d);483.21(b)(1) DEVELOP | F 279 | | |

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| F 279 SS=D | Continued From page 16<br>COMPREHENSIVE CARE PLANS<br><br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR | F 279 | | |

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| F 279 | Continued From page 17<br>recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative (s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and interviews the facility failed to develop a comprehensive Care Plan for 1 resident (#13) of 33 residents reviewed in stage 2 sample.<br><br>The findings included:<br><br>Medical record review revealed Resident #13 was admitted to the facility on 3/12/16 with the following diagnoses including Unspecified Dementia with Behavioral Disturbance, Attention and Concentration Deficit following other Cerebrovascular Disease, Major Depressive Disorder, Schizoaffective Disorder and Acute Kidney Failure. | F 279 | | |

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| F 279 | Continued From page 18<br>Medical record review revealed a physician order dated 3/15/16 for Paxil (antidepressant) 20mg (milligram) daily related to Major Depressive Disorder and physician order dated 8/1/16 for Risperdal (antipsychotic) 0.25mg for Psychosis related to Schizoaffective Disorder. Further review revealed a Physician order dated 1/16/17 for "...Targeted Behaviors: 0=none, 1=Crying, 2=restless/pacing, 3=refusing to eat, 4=withdrawn behavior, 5=other-document behavioral progress note every shift..."<br><br>Medical record review of the Annual Minimum Data Set (MDS) dated 2/23/17 revealed a Brief Interview for Mental Status (BIMS) score of 3 of 15 indicating severe cognitive impairment. Further review revealed over the 7 days look-back period the resident received the following medications: antipsychotic, antidepressant, insulin & diuretic.<br><br>Medical record review of the Care Plan dated 3/3/17 failed to develop a behavioral care plan with interventions.<br><br>Interview with the Director of Nursing (DON) on 5/3/17 at 1:52 PM in the conference room confirmed the facility failed to develop a behavioral care plan with interventions. | F 279 | | |
| F 280 SS=D | 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>483.10<br>(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br><br>(i) The right to participate in the planning process, | F 280 | | |

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| F 280 | Continued From page 19<br>including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br><br>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>(iv) The right to receive the services and/or items included in the plan of care.<br><br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--<br><br>(i) Facilitate the inclusion of the resident and/or resident representative.<br><br>(ii) Include an assessment of the resident's strengths and needs.<br><br>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(2) A comprehensive care plan must be-<br><br>(i) Developed within 7 days after completion of | F 280 | | |

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| F 280 | Continued From page 20<br>the comprehensive assessment.<br><br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br><br>(A) The attending physician.<br><br>(B) A registered nurse with responsibility for the resident.<br><br>(C) A nurse aide with responsibility for the resident.<br><br>(D) A member of food and nutrition services staff.<br><br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br><br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br><br>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, interview, and observation the facility failed to update or revise the comprehensive care plan for 2 resident's (#3,#65) related to accidents, 1 resident (#112) related to behaviors, and 1 resident (#137) related to medication review of 33 residents | F 280 | | |

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| F 280 | Continued From page 21<br>reviewed in the stage 2 sample.<br><br>The findings included:<br><br>Medical record review revealed Resident #3 was admitted to the facility on 11/13/13 with diagnoses including Mental Disorder due to known Physiological Condition, Diabetes Mellitus Type II, Hypertension, Cardiac Pacemaker, Major Depressive Disorder, Mood Disorder, Attention and Concentration Deficit following Cerebrovascular Accident, Anxiety Disorder, Peripheral Vascular Disease, Alzheimer's Disease and Osteoarthritis.<br><br>Medical record review of the Quarterly Minimum Data Set (MDS) dated 2/1/17 revealed Resident #3 was severely cognitively impaired for making decisions, and had no identified skin conditions.<br><br>Medical record review of progress note dated 2/13/17 at 3:16 PM revealed "...pt [patient} has a red area with a blister approx. 0.5 cm [centimeter] on her left anterior thigh. This was where she had spilled coffee..."<br><br>Medical record review of Weekly Wound Evaluation dated 2/20/17 revealed "...coffee burn..." "...4cm width by 4 cm length and 0.5 cm in depth..."<br><br>Interview with Speech Therapist #1 on 5/2/17 at 1:47 PM at the nursing station revealed Resident #3 "...was drinking coffee and when she put the coffee cup down on the table, it was too close to the edge and fell in her lap..."<br><br>Medical record review of the comprehensive care plan dated 2/1/17 revealed a problem of | F 280 | | |

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| F 280 | Continued From page 22<br>potential/actual impairment to skin integrity related to dry skin. Further medical record review revealed no care plan revision addressing the coffee burn.<br><br>Interview with the Director of Nursing (DON) on 5/3/17 at 2:42 PM in the conference room revealed, when asked if the comprehensive care plan was updated when Resident #3 suffered a burn related to a coffee spill, she stated "...care plan was not updated..." Further interview with the DON confirmed the facility failed to update the comprehensive care plan to reflect Resident #3's burn.<br><br>Interview with MDS Coordinator and MDS Coordinator's assistant on 5/3/17 at 3:23 PM in the MDS office revealed, when asked if the comprehensive care plan was updated when Resident #3 suffered a burn from a coffee spill, she stated "the care plan should have been revised to at least include the treatments..." During continued interview, the MDS Coordinator confirmed the facility failed to update the comprehensive care plan.<br><br>Medical record review revealed Resident #65 was admitted to the facility on 11/10/16 and readmitted on 3/16/17 with diagnoses including Chronic Obstructive Pulmonary Disease, Failure to Thrive, and Depression.<br><br>Medical record review of the Quarterly Minimum Data Set (MDS) dated 4/30/17 revealed Resident #65 scored 1 on the Brief Interview for Mental Status (BIMS) indicating he was severely impaired cognitively. Continued review revealed Resident #65 required extensive assistance of 1 person for transfers and dressing; was dependent | F 280 | | |

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| F 280 | Continued From page 23<br>on 2 people for grooming and bathing; was always incontinent of bowel and bladder; and was identified as having falls.<br><br>Review of a fall investigation dated 3/15/17 revealed Resident #65 was found sitting on the floor near the bed trying to reach for the call light lying on the floor at the foot of the bed. Intervention included call light audit and staff education to ensure call light is within easy reach. There is no documentation whether the bed alarm was in place and sounding.<br><br>Review of a second fall investigation dated 3/15/17 revealed Resident #65 was found lying on the floor on his left side with bleeding from the left side of the head above left eye. He was sent to the Emergency Room for evaluation and treatment. Interventions included transported to Emergency Department (ED) for evaluation and Physical Therapy (PT) revaluate return to facility. There is no documentation whether the bed alarm was in place and sounding.<br><br>Review of a fall investigation dated 3/24/17 revealed Resident #65 sitting on the mat beside the bed. He stated he was turning over in bed and rolled out. Interventions included a bed alarm and staff education to ensure appropriate interventions are in place and working.<br><br>Review of a fall investigation dated 4/10/17 revealed Resident #65 was found on the floor beside the bed on his hands and knees with his head on the floor. He leaned over the concave mattress and slid to the floor. The floor mat was not at the bedside. The intervention was to have a lab draw due to increased confusion. | F 280 | | |

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| F 280 | Continued From page 24<br>Review of a fall investigation dated 4/14/17 revealed the resident was lying on the floor in front of his wheelchair. He stated he was going to get some coffee. The self-release lap belt was not alarming; had previously been secured with velcro; while metal alarm attachment was not connected. Resident #65 sustained an abrasion to the right side of the head measuring 0.8 centimeters (cm) x 2.0 cm x 0.2 cm. Interventions included :<br>1. Observed self release lap belt on and working properly<br>2. Instructed staff members on properly securing belt and making sure metal connections are touching so alarm will be activated when belt is removed.<br>3. Non skid socks in place at all times.<br>4. Staff to take all equipment needed into room when providing assistance with ADLs.<br><br>Medical record review of a fall investigation dated 4/23/17 revealed Resident #65 was observed moving himself from the edge of the bed to the floor mat and positioned himself in a sitting position on the mat. When asked what he was doing said "I don't know". The intervention was to encourage the resident to attend fine dining for meals.<br><br>Medical record review of the Comprehensive Care Plan revised 4/14/17 revealed interventions of:<br>1. call light within reach of resident<br>2. ensuring self-release safety belt was applied properly<br>3. ensure interventions were in place and working<br>4. wearing non-skid socks at all times<br>were not included in the care plan. | F 280 | | |

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| F 280 | Continued From page 25<br>Interview with the Director of Nursing (DON) on 5/3/17 at 2:20 PM in the conference room confirmed the interventions were not included in the revision of the care plans. Continued interview revealed there was a lack of communication between nursing and the MDS staff who actually revise the care plans.<br><br>Review of facility policy, Abuse and Event Management Standard, revised 9/15 revealed "...The resident's care plan is to be updated to reflect interventions to reduce the risk of reoccurrence of this behavior..."<br><br>Medical record review revealed Resident #112 was admitted to the facility on 12/13/14 and readmitted on 12/17/16 with diagnoses including Huntington's Disease, Restlessness and Agitation, Other Specified Mental Disorders due to known Physiological Condition, Depression, Muscle Weakness, Ataxic Gait, Anxiety, and History of Falling.<br><br>Medical record review of the 5-day MDS assessment dated 12/13/16 revealed Resident #112 had a BIMS of 14 indicating the resident was cognitively intact.<br><br>Medical record review of a nurse's note dated 12/2/16 revealed Resident #112 "...had refused medications all day...heard a loud noise coming from the fine dining room. As we approached we saw a fire extinguisher on one of the tables and the pin was pulled. When resident was asked why he did this he said, 'I am a fireman.' " Continued review revealed when the nurse spoke to the resident he was talking to himself and grabbing at things in the air and the resident was also trying to drink coffee that was in a coffee pot. Further | F 280 | | |

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| F 280 | Continued From page 26<br>review revealed "...Resident would stumble and lose balance when walking around. Resident would fall into chairs and sit for awhile, then he would get back up and start pacing again. Resident was trying to punch a code into door alarm and was trying to push the door open. Then resident would say he doesn't trust anyone...Once the EMT's [Emergency Medical Technician's] started talking to him he said, 'No I am not going and I am not trying to be mean.' It took several hours to convince resident to go to the ER [Emergency Room] to be checked out..."<br><br>Medical record review of a nurse's note dated 12/12/16 revealed "...resident continues to pace and stay up most of the night. While awake he is very active. Seems to shy from help since return from recent hospitalization..."<br><br>Medical record review of a nurse's note dated 12/15/16 revealed "...resident having increased agitation towards mother and staff, resident attempting to pull fire alarm on hall and was found walking down hall holding butter knife...Knife removed from resident without incident, notified NP [Nurse Practioner] received new order to send resident to...ER..."<br><br>Medical record review of a nurse's note dated 12/17/16 revealed "...Resident in hallway on 400 hall, lifting his wheelchair over his head and walking down the hall and slamming it down on the floor. At this time there was other residents in the hallway. This nurse said '...put the wheelchair down and have a seat.' Resident put the chair down and sat down..."<br><br>Medical record review of a nurse's note dated 12/17/16 revealed "...Resident running up and | F 280 | | |

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| F 280 | Continued From page 27<br>down hallways going into resident's rooms only would take lortab for night time meds. Does not do well when anyone approaches him or gets close. Attempted to get into nurses bag and then attempted to pull fire alarm...Going into storage room stating a football player gave him all that stuff in there..Will continue to monitor..."<br><br>Medical record review of a nurse's note dated 12/18/16 revealed "...Resident got a hold of fire extinguisher and pulled pin and ran down 200 hallway spraying every where...Told resident to stop but he would not. Fire alarm went off and 911 called for help. LPN [Licensed Practical Nurse] and CNA [Certified Nursing Assistant] put all residents back in their rooms and doors closed. Back door to 200 hallway opened. Then as help was arriving including police, this resident run down 500 hallway. Police approached him and attempted to just talk to him but he made a fist and attempted to hit one of the officers in which all 4 officers restrained him and hand cuffed him and put him in the patrol car...Other residents assessed per EMT, and all resident's from 200 hallway brought to activity room after air had cleared of spray residue..."<br><br>Medical record review of the Care Plan with date initiated 12/23/14 revealed "...the resident has potential to demonstrate verbally abusive behaviors r/t [related to] poor functional control related to Huntington's disease...Goal...the resident will demonstrate effective coping skills through the review date...Interventions...Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation [12/23/14]...observe resident for any further instances and remove from situation; report to supervisor, social | F 280 | | |

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| F 280 | Continued From page 28<br>services, administration and physician as needed [12/23/14]...psych (Psychiatric) services to eval [evaluate] and treat related to anxiety and inappropriate behaviors [1/28/15]...remind resident to not go into other resident's rooms without permission [5/18/16]..."<br><br>Medical record review of the Care Plan with date initiated of 5/12/15 revealed "...The resident has episodes of sleeplessness and requires antidepressant medication r/t insomnia/restlessness...Goal...The resident will show decreased episodes of s/sx [signs/symptoms] of insomnia/restlessness through the review date...Interventions...observe/document/report to MD [Medical Doctor] prn [as needed] ongoing s/sx of insomnia/restlessness unaltered by meds: i.e. [for example] irritable,agitation,disrupted sleep,fatigue..."<br><br>Medical record review of the Care Plan with date initiated 9/29/16 revealed "...The resident has potential for episodes of insomnia related to history of and requires use of an melatonin...Goal...The resident will be free of any discomfort related to insomnia through the review date...Interventions...observe for signs of sleeplessness. Document and notify physician prn..."<br><br>Medical record review of the Care Plan with date initiated 8/23/16 revealed "...The resident uses psychotropic medications r/t psychosis. Goal -The resident will be/remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. The resident will | F 280 | | |

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| F 280 | Continued From page 29 | F 280 | | |

reduce the use of psychoactive medication through the review date. Interventions included: Administer medications as ordered. Observe/document for side effects and effectiveness..."

Medical record review of the Care Plan with date initiated 5/31/16 revealed "...The resident uses, anti-anxiety medications r/t Anxiety disorder.Goal: The resident will show decreased episodes of s/sx of anxiety through the review date. Interventions: Give anti-anxiety medications ordered by physician. Observe/document side effects and effectiveness..."

Interview on 5/3/17 at 2:50 PM with the DON in the conference room revealed there was a lack of communication between nursing and the MDS staff who actually revise the care plans. Continued interview confirmed the facility failed to update the care plans for Resident #112 to include any additional interventions for the behaviors exhibited in 12/16.

Medical record review revealed Resident #137 was admitted to the facility on 5/2/16, readmitted on 6/28/16 and 4/20/17 with diagnoses including Encephalopathy, Chronic Pain, Fibromyalgia, Dementia with Behaviors, Alzheimer's, Diabetes Mellitus Type II, Borderline Personality Disorder, Congestive Heart Failure, Depression, and Anxiety.

Medical record review of the comprehensive care plan dated 5/4/16 and revised 4/21/17, revealed the resident used anti-anxiety medications r/t (related to) Anxiety disorder. The intervention was, "...Give anti-anxiety medications ordered by the physician..." No nonpharmacological

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| F 280 | Continued From page 30<br>interventions were included.<br><br>Medical record review of the comprehensive care plan dated 5/4/16 and revised 4/21/17, revealed the resident used antidepressant medication r/t Depression. The intervention was, "...Give antidepressant medications ordered by the physician..." No nonpharmacological interventions were included.<br><br>Medical record review of the comprehensive care plan dated 3/10/17 and revised on 4/21/17 revealed the resident has pressure ulcer on left heel.<br><br>Medical record review of a Weekly Wound Evaluation dated 4/3/17 revealed the resident did not have an unhealed pressure ulcer at Stage 1 or higher. Continued review revealed a pressure ulcer to the left heel had resolved on 4/3/17.<br><br>Interview with RN (Registered Nurse) #3 on 5/3/17 at 4:00 PM in the Nurse's Station confirmed Resident #137 did not have any pressure ulcers.<br><br>Interview with the Director of Nursing (DON) on 5/3/17 at 1:45 PM in the Conference Room confirmed the comprehensive care plan for Resident #137 did not reflect her accurate status. Continued interview confirmed the facility failed to update or revise the comprehensive care plan for the resident. | F 280 | | |
| F 281 SS=D | 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>(b)(3) Comprehensive Care Plans | F 281 | | |

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| F 281 | Continued From page 31<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, interview, and facility policy review, the facility failed to follow the comprehensive care plan for 1 resident (#2) related to floor mat placement, and failed to appropriately transcribe physician's orders for 2 resident's (#13, #137) of 33 resident's reviewed in the stage 2 sample.<br><br>The findings included:<br><br>Medical record review revealed Resident #2 was admitted to the facility on 7/6/16 with diagnoses including Contusion of other part of head and neck, Acute and Chronic Kidney Failure, Difficulty Walking, Altered Mental Status, Vascular Demetnia, and Essential Hypertension.<br><br>Medical record review of Physician's order dated 1/24/17 revealed "mat to bedside every shift." Continued review revealed the Risk for falls care plan dated 1/31/17 identified an actual fall which occurred on 1/24/17 and resulted in redness to the Resident #2's posterior head and a skin tear to her left arm. The Care plan interventions included floor mats to bedside and this task was assigned to the nursing department. Further review of department was responsible for this task. Review of the facility's form titled "MDS Kardex Report for the Manchester Health Care Center-SNF" (a method for communicating Resident care information to Certified Nursing Assistants (CNAs) revealed no communication to | F 281 | | |

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| F 281 | Continued From page 32<br>the CNAs regarding the Resident's need for the placement of fall mats.<br><br>Observations on 5/1/17 at 10:44 AM and 2:20 PM in Resident #2's room revealed the resident in the bed without floor mats to the bedside. Continued observations on 5/2/17 at 7:08 AM, 1:04 PM, 1:27 PM, and 2:45 PM in Resident #2's room revealed the Resident in bed without floor mats to the bedside. Further observation on 5/3/17 at 1:33 PM in Resident #2's room revealed resident in bed without floor mats to the bedside.<br><br>Interview with CNA # 1 on 5/2/17 at 2:45 PM on the 100 hallway revealed CNA #1 was familiar with the Resident #2's care but had no knowledge of the need for floor mats. Continued interview with CNA #9 on 5/3/17 at 1:25 PM on the 100 hallway revealed CNA #9 had no knowledge of the need for floor mats in Resident #2's room. Further interview with Licensed Practical Nurse (LPN #3) on 5/3/17 at 1:25 PM on the 100 hallway confirmed the facility failed to place floor mats to Resident #2's bedside.<br><br>Review of facility policy, Physician's Orders, revised 2010 revealed, "..Physicians' Orders include...supporting diagnosis...It is the policy of this facility that all Physician's orders will be appropriately transcribed and noted by a licensed nurse...The nurse who notes the order will transcribe the order onto the appropriate Medication Administration Record...A licensed nurse...will review all physicians' verbal and/or telephone orders on a daily basis. The nurse will indicate his/her review and verification of accurate implementation by the nurse who noted the order, by documenting in red ink beneath the previous nurse's signature: '24 hour Order | F 281 | | |

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| F 281 | Continued From page 33<br>Check...When a verbal or telephone order is received by a nurse, documentation of the order on the Physician's Order Form must include: (1) the mode of transmission (v.o. or t.o.) [verbal order or or telephone order] (2) the prescribing physician's name (3) the date and time (including AM or PM) of the order (4) the name and professional designation of the nurse..."<br><br>Medical record review revealed Resident #13 was admitted to the facility on 3/12/16 with the following diagnoses including Unspecified Dementia with Behavioral Disturbance, Attention and Concentration Deficit following other Cerebrovascular Disease, Major Depressive Disorder, Schizoaffective Disorder and Acute Kidney Failure.<br><br>Medical record review revealed a Physician's order dated 3/15/16 for Paxil (antidepressant) 20 mg (milligram) daily related to Major Depressive Disorder and a Physician's order dated 8/1/16 for Risperdal (antipsychotic) 0.25 mg for Psychosis related to Schizoaffective Disorder.<br><br>Medical record review of the Annual Minimum Data Set (MDS) dated 2/23/17 revealed a Brief Interview for Mental Status (BIMS) score of 3 of 15 indicating severe cognitive impairment. Further review revealed over the 7 days look-back period the resident received the following medications: antipsychotic, antidepressant, insulin & diuretic.<br><br>Medical record review revealed the Consultant Pharmacist Reviews for Resident #13 were completed monthly from May 2016 until April 2017 with recommendations on 10/18/16 and 1/16/17. The October 2016 Consultant | F 281 | | |

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| F 281 | Continued From page 34<br>Pharmacist Recommendation Summary (CPRS) for Risperdal revealed "...CMS [Center for Medicare and Medicaid Systems] requires documentation for GDR [Gradual Dose Reduction] consideration twice during the first year, in separate quarters, and annually after first year; has an FDA [Federal Drug Administration] BOXED WARNING concerning a 1.6-1.7 fold increase in mortality in geriatric patients with dementia. Most deaths occurred due to heart-related events or infections; GDR is NOT RECOMMENDED if detrimental to the resident, if deterioration is expected, or if documentation is available of FAILED GDR failed in this facility ..." The Physician responded " ...DECREASE to RISPERDAL 0.125mg/HALF-TABLET QD [once daily] @ [at] 1PM for PSYCHOSIS."<br><br>Medical record review of the October 2016 Consultant Pharmacist Recommendation Summary for Paxil revealed " ...After treatment for 4-9 months following the acute phase, whether a patient continues as this maintenance dose depends on the established history of previous depressive episodes and the physician assessment. It is time to review IF a trial dose reduction of this antidepressant is indicated, per CMS Guidelines of ALL Psychoactive Medications regardless of indication. GDR is NOT RECOMMENDED if detrimental to the resident, if deterioration is expected, or if documentation is available of FAILED GDR failed in this facility..." Physician responded "..DECREASE to PAXIL 10 mg QD DEPRESSION..." Continued review revealed the Physician's signature date of 5/2/15.<br><br>Interview with the Director of Nursing (DON) on 5/3/17 at 1:52 PM in the conference room revealed the CPRS were sent to her via email | F 281 | | |

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| F 281 | Continued From page 35<br>after which a copy was sent to Medical Records. Medical Records then sent a copy to the attending Physician. Once the CPRS was reviewed by the Physician and returned to Medical Records, the DON received a signed copy and another copy went to the floor nurse, who was responsible for writing any new orders in regards to medications changes/GDR. The DON confirmed the October 2016 CPRS was not reviewed in a timely manner. The DON confirmed date signed by Medical Director on the October 2016 CPRS was 5/2/15. The DON confirmed the October 2016 CPRS was dated by the Physician on 5/2/15 but should have been dated 5/2/17. The DON confirmed the GDR recommendation order was placed in the computer system on 5/2/17 without a phone or written order in the chart.<br><br>Interview with LPN #4 on 5/3/17 at 3:40 PM in the conference room revealed once the CPRS reviews were received from the DON they were sent to the attending Physician. Further interview with LPN #4 revealed a response from the attending Physician was expected between 2-4weeks and if a response was not received the recommendation was sent to the Medical Director. Once the recommendation was signed by a physician, it was returned to Medical Records where it was copied and placed into the file. A copy was given to the DON to log and another copy to the Nurse responsible for the resident, who then was responsible for writing any new orders, if applicable.<br><br>Telephone interview with the Medical Director on 5/3/17 at 3:55 PM revealed he would receive the CPRS when the attending Physician failed to respond in a timely manner. Further interview with | F 281 | | |

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| F 281 | Continued From page 36<br>the Medical Director revealed the CPRS was to be completed within 30 days and it was not normal practice for it to take 5-7 months. The Medical Director stated the October 2016 CPRS was signed on 5/2/17 and not 5/2/15 as he had written.<br><br>Telephone interview completed with the Consultant Pharmacist (CP) on 5/3/17 at 5:45 PM revealed after the CPRS was completed they were posted on a private website within 2-3 days of review, after which the DON had access. It was the impression of the CP that the DON notified the attending Physician of any recommendations and/or provided the summary to the attending Physician. The expectation was to have a response to the recommendation within 30 days. The CP stated if she had concerns for the welfare of the resident, contact would be made with the DON. The CP confirmed no response was received from the October 2016 CPRS recommendation and another request was made in February 2017.<br><br>Medical record review revealed Resident #137 was admitted to the facility on 5/2/16, readmitted on 6/28/16 and 4/20/17 with diagnoses including Encephalopathy, Chronic Pain, Fibromyalgia, Dementia with Behaviors, Alzheimer's, Diabetes Mellitus Type II, Borderline Personality Disorder, Congestive Heart Failure, Depression, and Anxiety.<br><br>Medical record review of a significant change Minimum Data Set (MDS) dated 3/16/17 revealed the resident had active diagnoses including Anxiety Disorder, Depression, and Bi-polar Disease. | F 281 | | |

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| F 281 | Continued From page 37<br>Medical record review of Order Summary Reports from 12/1/16-4/21/17 revealed Resident #137 received Klonopin (also known as Clonazepam; a sedative used to treat seizures, panic disorder, and anxiety) regularly and as needed (PRN) for Anxiety.<br><br>Medical record review of a prescription dated 4/20/17 from the resident's PCP (Primary Care Physician) revealed, "... Clonazepam 0.125 mg disintegrating tablet 1 (one) tablet on the tongue every evening at bedtime for seven days..."<br><br>Medical record review of an Order Summary Report dated 4/21/17 revealed an active order dated 4/20/17 for "Clonazepam Tablet Dispersible 0.125 MG Give 1 tablet orally at bedtime for Seizure Disorder until 5/3/17 On the tongue..."<br><br>Interview with the Nurse Practitioner on 5/3/17 at 10:45 AM in the MDS office confirmed Resident #137 did not have a diagnosis of Seizures. Continued interview confirmed the resident had taken Klonopin for 20 years for her anxiety disorder.<br><br>Interview with Registered Nurse (RN) #2 on 5/3/17 at 11:10 AM in the Nurse's Station confirmed she had transcribed the physician ordered prescription into the electronic record. Continued interview with the RN revealed the medication Clonazepam defaulted to a diagnosis of seizures. Further interview with RN #2 when asked how she determined an indication for the medication if the physician failed to list one stated, "I look at their diagnoses and pick the one that makes sense." Continued interview when asked what the facility policy was regarding transcribing physician's orders, the RN stated, "I | F 281 | | |

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| F 281 | Continued From page 38<br>don't know, but that's what I do." The RN confirmed she failed to clarify the diagnosis for the medication with the ordering physician, and failed to appropriately transcribe a physician's order into the electronic record.<br><br>Medical record review revealed Resident #2 was admitted to the facility on 7/6/16 with diagnoses including Unspecified Contusion to Neck, Contusion to Head, Chronic Kidney Disease, Cognitive Communication Deficit, and Dementia.<br><br>Medical record review of the Minimum Data Set (MDS) dated 1/3/17 revealed a Brief Interview Mental Status (BIMS) score of 8 indicating severe cognitive impairment. Further review revealed the resident required extensive assistance for bed mobility, transfers, hygiene and was always incontinent of bladder and bowels.<br><br>Medical record review of a physician order dated 1/24/17 revealed fall mat to bedside every shift.<br><br>Medical record review of the comprehensive care plan for falls dated 1/31/17 revealed an intervention for fall mat to the floor.<br><br>Review of the Certified Nurse Aid (CNA) kardex (a method for communicating resident care needs to CNAs) revealed no communication to the CNAs regarding the Resident's need for the placement of the fall mat.<br><br>Observations on 5/1/17 at 10:44 am and 2:20 PM in Resident #2's room revealed the resident was in bed without a floor mat to the bedside.<br><br>Observations on 5/2/17 at 7:08 AM, 1:04 PM, 1:27 PM, and 2:45 PM in Resident #2's room | F 281 | | |

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| F 281 | Continued From page 39<br>revealed the resident was in bed without a floor mat to the bedside.<br><br>Observation on 5/3/17 at 1:33 PM in Resident #2's room revealed the resident was in bed without a floor mat to the bedside.<br><br>Interview with CNA #1 on 5/2/17 at 2:45 PM on the 100 hallway revealed CNA #1 was familiar with Resident #2's care but had no knowledge of the need for a floor mat.<br><br>Interview with CNA #9 on 5/3/17 at 1:25 PM on the 100 hallway revealed CNA #9 had no knowledge of the need for a floor mat in Resident #2's room.<br><br>Interview with LPN #3 on 5/3/17 at 1:25 PM on the 100 hallway confirmed the facility failed to place a floor mat to Resident #2's bedside. | F 281 | | |
| F 323 SS=E | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. | F 323 | | |

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| F 323 | Continued From page 40<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, review of facility investigation, interview, and facility policy, the facility failed to prevent falls for 1 resident (#65) of 4 residents reviewed.<br><br>The findings included:<br><br>Medical record review revealed Resident #65 was admitted to the facility on 11/10/16 and readmitted on 3/16/17 with diagnoses including Chronic Obstructive Pulmonary Disease, Failure to Thrive, and Depression.<br><br>Medical record review of the Quarterly Minimum Data Set (MDS) dated 4/30/17 revealed Resident #65 scored 1 on the Brief Interview for Mental Status indicating he was severely impaired cognitively. Continued review revealed Resident #65 required extensive assistance of 1 person for transfers and dressing; was dependent on 2 people for grooming and bathing; was always incontinent of bowel and bladder; and was identified as having falls.<br><br>Medical record review of the Fall Risk Assessment dated 3/15/17 revealed Resident #65 was a high fall risk. | F 323 | | |

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| F 323 | Continued From page 41<br><br>Review of a fall investigation dated 3/15/17 revealed Resident #65 was found sitting on the floor near the bed trying to reach for the call light lying on the floor at the foot of the bed. Intervention included call light audit and staff education to ensure call light is within easy reach. There was no documentation the bed alarm was in place and sounding.<br><br>Review of a second fall investigation dated 3/15/17 revealed Resident #65 was found lying on the floor on his left side with bleeding from the left side of the head above the left eye. He was sent to the Emergency Room for evaluation and treatment. Interventions included transported to Emergency Department (ED) for evaluation and Physical Therapy (PT) revaluate on return to the facility. There was no documentation the bed alarm was in place and sounding.<br><br>Review of a fall investigation dated 3/24/17 revealed Resident #65 sitting on the mat beside the bed. He stated he was turning over in bed and rolled out. Interventions included a bed alarm and staff education to ensure appropriate interventions are in place and working.<br><br>Review of a fall investigation dated 4/10/17 revealed Resident #65 was found on the floor beside the bed on his hands and knees with his head on the floor. He leaned over the concave mattress and slid to the floor. The floor mat was not at the bedside but the bed alarm was sounding. The intervention was to have a lab draw due to increased confusion.<br><br>Review of a fall investigation dated 4/14/17 revealed the resident was lying on the floor in | F 323 | | |

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| F 323 | Continued From page 42<br>front of his wheelchair. He stated he was going to get some coffee. The self-release lap belt was not alarming; had previously been secured with velcro; while metal alarm attachment was not connected. Resident #65 sustained an abrasion to the right side of the head measuring 0.8 centimeters (cm) x 2.0 cm x 0.2 cm. Interventions included :<br>1. Observed self release lap belt on and working properly<br>2. Instructed staff members on properly securing belt and making sure metal connections are touching so alarm will be activated when belt is removed.<br>3. Non skid socks in place at all times.<br>4. Staff to take all equipment needed into room when providing assistance with ADLs.<br><br>Review of a fall investigation dated 4/23/17 revealed Resident #65 was observed moving himself from the edge of the bed to the floor mat and positioned himself in a sitting position on the mat. When asked what he was doing said "I don't know." The intervention was to encourage the resident to attend fine dining for meals.<br><br>Interview with Licensed Practical Nurse (LPN) #5 on 5/3/17 at 3:00 PM on the 200 hall, revealed staff checked the presence of the bed and chair alarms each shift and documented on the Medication Administration Record (MAR) the alarm pads were present. Continued interview revealed she was unsure how to recognize when the battery was low but Restorative came around and checked the alarms.<br><br>Interview with LPN #6 on 5/3/17 at 3:10 PM on the 300 hall revealed all staff checked the alarms for their presence each shift and documented it | F 323 | | |

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| F 323 | Continued From page 43<br>on the MAR. When the battery was low it beeped to alert staff and either nursing or Restorative will replace the batteries.<br><br>Interview with LPN #7 on 5/3/17 at 3:30 PM on the 500 hall revealed all staff checked the presence of alarms and nurses documented their presence on the MAR. Usually she would check the alarm and pad when she transferred a resident from bed to chair. The presence of the alarm was documented on either the MAR or TAR (Treatment Administration Record). When the battery was low it made a noise and staff called Restorative to change batteries.<br><br>Interview with the Restorative CNA on 5/3/17 at 4:00 PM revealed she will make rounds on the halls occasionally to check if bed and chair alarms were working by pressing on them until they beep. If there was no response then there was a problem with the battery or the box. There was a light on the box which blinked when it was time to replace the battery or check the function of the pad.<br><br>Interview with the Director of Nursing (DON) on 5/3/17 at 4:40 PM in the conference room revealed alarms are checked every shift by nurses and signed on the MAR. Continued interview revealed on the self-releasing seat belt the metal pieces were not touching so it did not reset the alarm. Further interview revealed when the battery is low there is a flashing light on the box to alert staff it is time to change the battery. Continued interview revealed the DON confirmed on 2 occasions the alarms meant to alert staff of unsafe movements by Resident #65 were not functioning with resultant falls. Further interview revealed the DON confirmed the facility does not | F 323 | | |

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| F 323 | Continued From page 44<br>have a protocol in place to check batteries of alarms on a regular basis predisposing residents to a non-functional alarm. | F 323 | | |
| F 329 SS=D | 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or<br><br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>483.45(e) Psychotropic Drugs.<br>Based on a comprehensive assessment of a resident, the facility must ensure that--<br><br>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; | F 329 | | |

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| F 329 | Continued From page 45<br><br>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy review, medical record review and interviews, the facility failed to ensure the Consultant Pharmacist Recommendation Summary was received, reviewed and responded to by a Physician in a timely manner for 1 resident (#13) of 5 residents reviewed.<br><br>The findings included:<br><br>Review of facility policy, Consultant Pharmacist Reports...Documentation and Communication of Consultant Pharmacist Recommendations, dated August 2012 revealed "...Comments and recommendation concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review..."<br><br>Medical record review revealed Resident #13 was admitted to the facility on 3/12/16 with the following diagnoses including Unspecified Dementia with Behavioral Disturbance, Attention and Concentration Deficit following other Cerebrovascular Disease, Major Depressive Disorder, Schizoaffective Disorder and Acute Kidney Failure.<br><br>Medical record review revealed a Physician order dated 3/15/16 for Paxil (antidepressant) 20 mg (milligram) daily related to Major Depressive Disorder and Physician order dated 8/1/16 for | F 329 | | |

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| F 329 | Continued From page 46<br>Risperdal (antipsychotic) 0.25 mg for Psychosis related to Schizoaffective Disorder.<br><br>Medical record review of the Annual Minimum Data Set (MDS) dated 2/23/17 revealed a Brief Interview for Mental Status (BIMS) score of 3 of 15 indicating severe cognitive impairment. Further review revealed over the 7 days look-back period the resident received the following type of medications: antipsychotic, antidepressant, insulin and diuretic.<br><br>Medical record review revealed the Consultant Pharmacist Reviews for Resident #13 were completed monthly from May 2016 until April 2017 with recommendations on 10/18/16 and 1/16/17. The October 2016 Consultant Pharmacist Recommendation Summary (CPRS) for Risperdal revealed "...CMS [Center for Medicare and Medicaid Systems] requires documentation for GDR [Gradual Dose Reduction] consideration twice during the first year, in separate quarters, and annually after first year; has an FDA [Federal Drug Administration] BOXED WARNING concerning a 1.6-1.7 fold increase in mortality in geriatric patients with dementia. Most deaths occurred due to heart-related events or infections; GDR is NOT RECOMMENDED if detrimental to the resident, if deterioration is expected, or if documentation is available of FAILED GDR failed in this facility..." The Physician responded " ...DECREASE to RISPERDAL 0.125mg/HALF-TABLET QD [once daily] @ [at] 1PM for PSYCHOSIS..." Medical record review of the October 2016 CPRS for Paxil revealed "...After treatment for 4-9 months following the acute phase, whether a patient continues as this maintenance dose depends on the established history of previous depressive | F 329 | | |

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| F 329 | Continued From page 47<br>episodes and the Physician assessment. It is time to review IF a trial dose reduction of this antidepressant is indicated, per CMS Guidelines of ALL Psychoactive Medications regardless of indication. GDR is NOT RECOMMENDED if detrimental to the resident, if deterioration is expected, or if documentation is available of FAILED GDR failed in this facility..." Physician responded "...DECREASE to PAXIL 10mg QD DEPRESSION..." Continued review revealed the Physician signature date of 5/2/15.<br><br>Interview with Licensed Practical Nurse (LPN) #3 on 5/3/17 at 1:42 PM on Hall 100 revealed the Nurse was responsible for writing any new orders for their residents that result from CPRS.<br><br>Interview with the Director of Nursing (DON) on 5/3/17 at 1:52 PM in the conference room revealed the CPRS were sent to her via email after which a copy was sent to Medical Records. Medical Records then sent a copy to the attending Physician. Once the CPRS was reviewed by the Physician and returned to Medical Records, the DON received a signed copy and another copy went to the floor Nurse, who was responsible for writing any new orders in regards to medications changes/GDR. The DON confirmed the October 2016 CPRS was not reviewed in a timely manner. The DON confirmed the date signed by the Medical Director on the October 2016 CPRS was 5/2/15. The DON confirmed the October 2016 CPRS was dated by the Physician on 5/2/15 but should have been dated 5/2/17. The DON confirmed the GDR recommendation order was placed in the computer system on 5/2/17 without a phone or written order in the chart. | F 329 | | |

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| F 329 | Continued From page 48<br>Interview with LPN #4 on 5/3/17 at 3:40 PM in the conference room revealed once the CPRS reviews were received from the DON they were sent to the attending Physician. Further interview with LPN #4 revealed a response from the attending Physician was expected between 2-4 weeks and if a response was not received the recommendation was sent to the Medical Director. Once the Recommendation was signed by a Physician, it was returned to Medical Records where it was copied and placed into the file. A copy was given to the DON to log and another copy to the Nurse responsible for the resident, who then was responsible for writing any new orders, if applicable.<br><br>Telephone interview with the Medical Director on 5/3/17 at 3:55 PM revealed he would receive the CPRS when the attending Physician failed to respond in a timely manner. Further interview with the Medical Director revealed the CPRS was to be completed within 30 days and it was not normal practice for it to take 5-7 months. The Medical Director stated the October 2016 CPRS was signed on 5/2/17 and not 5/2/15 as he had written.<br><br>Telephone interview completed with the Consultant Pharmacist (CP) on 5/3/17 at 5:45 PM revealed after the CPRS were completed they were posted on a private website within 2-3 days of review, after which the DON had access. It was the impression of the CP that the DON notified the attending Physician of any recommendations and/or provided the summary to the attending Physician. The expectation was to have a response to the recommendation within 30 days. The CP stated if she had concerns for the welfare of the resident, contact would be made with the | F 329 | | |

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| F 329 | Continued From page 49<br>DON. The CP confirmed no response was received from the October 2016 CPRS recommendation and another request was made in February 2017. | F 329 | | |
| F 364 SS=F | 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br><br>(d) Food and drink<br><br>Each resident receives and the facility provides-<br><br>(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature;<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the Food Code 2013, observation and interview, the facility dietary department failed to serve mechanically altered food at or greater than 135 degrees Fahrenheit (F) and failed to reheat the food to 165 degrees F prior to serving for 1 of 2 meal services observed for food temperatures.<br><br>The findings included:<br><br>Review of the Food Code 2013 revealed "...Reheating for Hot Holding...Section 3-403.11...TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the FOOD reach a temperature of at least...(165 degrees F) for 15 seconds..."<br><br>Observation on 5/1/17 beginning at 12:03 PM in the main dining room revealed the resident tray | F 364 | | |

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| F 364 | Continued From page 50<br>line meal service was in progress and a resident tray delivery cart was filled and being delivered to a unit. Further observation revealed Dietary Staff #2 obtaining food temperatures. Further observation revealed the White Beans with Chopped Ham (for mechanical soft diets) was 120 degrees F, the pureed White Beans with Ham was 110 degrees F, and the pureed Stewed Tomatoes was 90 degrees F. Further observation revealed the White Beans with Chopped Ham, pureed White Beans with Ham and the pureed Stewed Tomatoes were removed from the tray line and reheated. Further observation revealed the 3 items were replaced in the tray line with the temperatures of 152 degrees F for the White Beans with Chopped Ham, 142 degrees F for the pureed White Beans with Ham and 154 degrees F for the pureed Stewed Tomatoes and served to the residents.<br><br>Interview with the Certified Dietary Manager on 5/1/17 at 12:20 PM at the main dining room resident tray line confirmed the facility failed to serve food at or above 135 degrees F. Further interview confirmed the facility failed to reheat the food to 165 degrees F prior to serving the food to the residents. | F 364 | | |
| F 367 SS=D | 483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN<br><br>(e) Therapeutic Diets<br><br>(e)(1) Therapeutic diets must be prescribed by the attending physician.<br><br>(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a | F 367 | | |

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| F 367 | Continued From page 51<br>therapeutic diet, to the extent allowed by State law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy review, medical record review, observation and interview, the facility failed to obtain or clarify physician orders for therapeutic diets for 1 resident (#65) of 34 residents receiving therapeutic diets.<br><br>The findings included:<br><br>Review of facility policy, Physician Orders, revised 2010 revealed "....It is the policy of this facility that all medications and treatment protocols are ordered by the resident's physician or designee...Procedure...All Physician Orders for each resident shall be entered into the electronic medical record immediately upon receipt..."<br><br>Medical record review revealed Resident #65 was initially admitted to the facility on 11/10/16, was discharged to the hospital on 3/15/17, and readmitted to the facility on 3/16/17 with diagnoses including Pneumonia, Acute Exacerbation of Chronic Obstructive Pulmonary Disease, Tachycardia, Adult Failure To Thrive, Difficulty Walking, Enterocolitis due to Clostridium Colitis, Anxiety, and History of Scabies.<br><br>Medical record review of the 3/2017 Order Summary Report form signed by the physician on 3/3/17 revealed "...Diet: Regular diet, Mechanical Soft texture..." Further review of the medical record revealed no physician orders from 3/3/17 to 3/15/17 to change the diet.<br><br>Medical record review of the hospital transfer order sheet dated 3/16/17 revealed "...Diet: | F 367 | | |

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| F 367 | Continued From page 52<br>Continue prior nursing home orders..."<br><br>Medical record review of the Diet Order & (and) Communication form dated 3/17/17 signed by Registered Nurse (RN) #2 revealed "...Readmit [Readmission]...Diet order No Added Salt...Texture: Regular Mechanical Soft..."<br><br>Further medical record review of the physician orders dated 3/15/17 to 4/3/17 revealed no orders for a diet change.<br><br>Medical record review of the 4/2017 Order Summary Report form signed by the physician on 4/3/17 revealed "...Diet: Regular NAS [No Added Salt], Regular texture..."<br><br>Observation and interview on 5/2/17 at 1:39 PM in Resident #65's room revealed the resident in the room in a wheelchair. Further observation revealed the resident had missing, broken and stained teeth. Interview with Resident #65 revealed "...didn't like lunch much...didn't want anything else either...had no mouth pain and could eat anything if he wanted to..."<br><br>Interview with Certified Nurse Aide (CNA) #8 and Dietary Staff #1 on 5/2/17 at 1:42 PM on the 200 hall confirmed the CNA had assisted the resident with the lunch meal. Further interview with the CNA and Dietary Staff #1 revealed the resident had been served and had already eaten 100% of regular textured Bar-B-Que chicken when he asked the CNA to "...cut chicken up for him..." The CNA revealed she told the resident he had already eaten the chicken and asked if he wanted more, to which he replied he did. The CNA and Dietary Staff #1 confirmed the resident was provided more regular textured chicken and he | F 367 | | |

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| F 367 | Continued From page 53<br>ate 100% of it also.<br><br>Observation on 5/3/17 at 8:00 AM revealed the 200 hall resident tray delivery cart was on the hall and nursing staff was distributing the trays. Further observation revealed nursing staff setting up Resident #65's tray with a tray card identifying the diet as Regular Mechanical Soft with ground meat. Further observation revealed the resident received ground meat with gravy, scrambled eggs, biscuit, corn flakes, milk, orange juice and coffee. Further observation revealed the resident was feeding himself after the tray was set up. Continued observation at 8:25 AM revealed the resident was self-feeding the last of the corn flakes and had eaten 100% of everything else.<br><br>Interview with Registered Nurse (RN) #2 on 5/2/17 at 2:55 PM at the nursing station, after reviewing the physician orders from 3/3/17 to the readmission on 3/16/17, confirmed she had no explanation for the "No Added Salt" portion she had written on the Diet Order & Communication form. Further interview confirmed there was no physician order to change the diet from 3/3/17 from a Regular Mechanical Soft to the 3/17/17 No Added Salt Regular Mechanical Soft written on the communication form. Further interview with the RN, after reviewing the physician orders from the readmission on 3/16/17 to 4/3/17, confirmed there was no physician order to change the diet from Regular Mechanical Soft to Regular No Added Salt.<br><br>Interview with the Director of Nursing on 5/3/17 at 2:47 PM in the conference room, after reviewing the physician orders from 3/3/17 to 4/3/17, confirmed the facility failed to follow the policy to obtain a physician order to change the diet or to | F 367 | | |

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| F 367 | Continued From page 54<br>get diet clarification orders. | F 367 | | |
| F 371 SS=F | 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility dietary department failed to prevent possible contamination of clean dishes during 1 of 2 observed dish room operations and for possible contamination of exposed food on the steam table during 3 of 5 meal services observed.<br><br>The findings included: | F 371 | | |

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| F 371 | Continued From page 55<br><br>Observation on 5/1/17 at 9:02 AM in the dietary dish room, with the Certified Dietary Manager (CDM) present, revealed the dish machine was in operation. Further observation revealed 4 racks of clean dishes were air drying on the clean side of the dish machine. Further observation revealed a wall mounted fan with blackened hanging debris on the grate and blades was in operation and blowing directly on the 4 racks of clean dishes air drying on the clean side of the dish machine, possibly contaminating the clean dishes.<br><br>Interview with the CDM on 5/1/17 at 9:05 AM in the dietary dish room confirmed the wall mounted fan with dirty grate and blades was blowing directly on the clean dishes drying on the clean side of the dish machine. Further interview confirmed the facility failed to prevent possible contamination of the dishes.<br><br>Observation of the resident main dining room tray line meal services on 5/1/17 at 12:03 PM, on 5/2/17 at 7:10 AM, and on 5/2/17 at 12:55 PM, revealed a ceiling air vent above and to the right of the steam table, the surrounding ceiling tiles, a light cover and a speaker cover, were coated with blackened hanging debris.<br><br>Interview with the CDM on 5/1/17 at 12:03 PM in the main dining room during the resident meal services confirmed the ceiling vent had blackened debris present and could possibly contaminate the food in the steam table area. | F 371 | | |